Developed in Cooperation With: Departments of Consumer & Industry Services, Community Health, and Education; Michigan State Medical Society; Michigan Association of Osteopathic Physicians an Dear Parent or Guardian: The following information is requested as that the school and the school a	d Surge	ons	PPRAISAL	☐ Child☐ Child☐ Child☐ Child☐			
The following information is requested so that the school and parer requested in Section I. Section II may be certified by transcription of doctor, nurse, and dentist. (BE SURE TO BRING YOUR CHILD'S II	of informate	together to tion from the TION REC	o meet the physical, intellect e certificate of immunization. ORDS TO THE EXAMINATION	ual , and emotional need The remaining sections ON.)	s of the child. Fill out the informatios (III, IV, V) are to be completed by		
PERSONAL							
Child's Name			Sex	Date of Birth			
Last First	t		Middle				
AddressNumber & Street			0.3	Today's Date			
			City Zi	р			
Parent's or Guardian's NameLast		First	Midd	Telephone (H	ome)		
Address			WINGO				
AddressNumber & Street			City Zip	Telephone (W	/ork)		
SECTION I — HEALTH HISTORY			SECTION II — IM	MUNIZATION			
Is your child having any of the problems listed below?	YES	NO	Statements such as "U Admission to school ma	P TO DATE" or "COMPL By be denied on the has	ETE" will not be accepted.		
Allergies or reactions: (for example, food, medication, or other)				,	es of the information.		
Hay fever, asthma, or wheezing		 	VACCINE		ADMINISTERED		
Eczema or frequent skin rashes			DTaP/DTP/DT/Td TYPE (Specify Type)	Mo/Day/Yr:	Mo/Day/Yr:		
Convulsions/Seizures				2.	7.		
5. Heart trouble				3.			
6. Diabetes					8.		
7. Frequent colds, sore throats, earaches				4.	- 9.		
(4 or more per year)			Haemophilus	5	10.		
Trouble with passing urine or bowel movements			influenzae type b	1.	3		
Shortness of breath				2.	4.		
10. Speech problems			POLIO IPV/OPV	1.	4.		
11. Menstrual problems			(Specify Type)	2.	5.		
12. Dental problems: date of last examination:				3.			
13. Other			Note: If Measles, Rubella the dosage must be repeated	or Mumps vaccines were g	given before 12 months of age,		
			MMR	Mo/Day/Yr	Mo/Day/Yr;		
Diagram			Varicella	1	-		
Please explain any problem areas identified above:			(Chickenpox) Chickenpox	1.			
			History of Disease	Yes No No	Date:		
			Hepatitis B HBV	1.	3.		
				2.			
			Pneumococcal Conjugate (PCV)	1.	3.		
				2.	4.		
· · · · · · · · · · · · · · · · · · ·			Other Vaccines				
					_		
					-		
	<u> </u>						
			Indicate physician diagnosis of disease or				
Does your child take any medication regularly?	YES 🗆	NO	laboratory evidence of immunity as applicable				
			VACCINES WAIVED DUE				
If yes, what medication?			REACTIONS/CONTRAINE RELIGIOUS OBJECTIONS	DICATIONS/ ————————————————————————————————————			
					to the best of my knowledge		
Reason for medication:	:						
Parent's Signature:			Validating Signature		Title Date		
					Date		

^{*}According to Act 368, Public Acts of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious, and other objections provided that waiver forms are properly prepared, signed, and delivered to school administrators. Forms for these exemptions are available at your school or local health department.

SECTION III - PHYSICAL EXAMINATION, INSPECTION, TESTS, AND MEASUREMENTS EXAMINATIONS AND/OR INSPECTIONS

ESSENTIAL FINDINGS DEVIATING FR	OM NORMAL	AND/OR RECON	MENDATIONS							
					-					
		7 m/h			. , , , , , , , , , , , , , , , , , , ,	****				
			D MEASUREMENTS							
	Normal	Under Care Referr	ed	•		Normal	Under Care	Referred		
Vision Tested? ☐ Yes ☐ No ☐ Ocular Muscle ☐ Other ☐ ☐	-		Urinalysis Done? □Yes □No Date	□Sugar □Albumin □Microscopic						
Hearing Tested? Audiometer Yes No Other Date	-		Blood Pressure Me ☐ Yes ☐ No Reading							
Hemoglobin/Hemotocrit Tested? ☐ Yes ☐ No		-	Height Other:	Weight						
Blood Lead Level Measured? Yes No Date Reading	_		Blood Lead Level re under	Blood Lead Level recommended for all children age six and under						
ESSENTIAL FINDINGS DEVIATING FR	OM NORMAL A	AND/OR RECOM	IMENDATIONS	1904		***		•		
Tuberculin Test (if given) Date		□Ne	gative Positive	mm	١.					
SECTION IV - RECOMMENDATION Is there any defect of vision, hearing, or If yes, please explain.		for which the sc	hool could help by seating	or other action?	□ Ye	es 🗆 No				
Should the student's activity be restricted	d because of a	ny physical defec	t or illness? □Yes □N	lo If ves. check h	pelow and	d explain d	learee of			
☐ Classroom ☐ Playground ☐ Gymn	asium 🗆 Swin	nming Pool 🗆 C	ompetitive Sports ☐ Car	mp ☐ Other		- CAPICITI C		Testriction.		
Examiner's Signature	Date		Examiner's Name (p	Examiner's Name (print or type)			Degree or License			
Number & Street C	ty	Zip	Telephon	ne	·					
SECTION V - DENTAL EXAMINATION	ON AND REC	COMMENDATION	ONS (OPTIONAL)							
I have examinedChild's Name	_ teeth and ma	ake the following	recommendations as for t	reatment:	·					
- Child o Marino		-								
	-					· · · · · · · · · · · · · · · · · · ·				
COMMENTS			Den	tist's Signature			Date			
O MINIENT 3							-			
				-						

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